MINNESOTA LIFE

NOTICE OF CLAIM FOR ACCELERATED BENEFIT

Group Division Claims • PO Box 64114 • St. Paul, Minnesota 55164-0114 • FOR CLAIM INFORMATION CALL: Toll Free 1 800 328-9442 – MN Local 651-665-3815

To present your claim under the Terminal Condition Option (Accelerated Benefit) of your policy, please fully complete this form.

PLEASE NOTE: Recently enacted legislation provides that benefits received under the Terminal Condition Option may not be included in your taxable income. However, benefits received under the Confinement or Hospice Care Option are likely to be included in your taxable income. You should seek assistance from your personal tax advisor to determine the taxability of benefits related to your individual situation. In addition, the receipt of benefits under this rider may adversely affect your eligibility for Medicaid or other government benefits or entitlements.

Part 1-Should be completed by the Employer.

Part 2-Should be completed by the claimant or authorized representative. If guardianship or power of attorney has been executed, please attach certified copies of the official designation.

Part 3-Should be completed by your physician. **PLEASE NOTE, WE ARE REQUESTING THAT COPIES OF YOUR MEDICAL RECORDS BE SUBMITTED WITH THIS FORM BY YOUR PHYSICIAN TO ASSIST IN EXPEDITING OUR REVIEW.**

Please **PRINT** or **TYPE** answers clearly, and answer all questions as completely as possible. Unanswered questions could result in additional requests for information and require additional time in processing your claim.

PART 1-EMPLOYER'S STATEMENT - To be completed by the authorized representative of the employer. If enrollment applications are maintained in your office, please attach a copy.

1. EMPLOYEE'S NAME (Last, First, Middle Initial)	2. POLICY NUMBER

3. DATE OF HIRE (Mo/Day/Yr)	4. EFFECTIVE DATE OF INSURANCE (Mo/Day/Yr)	5. DATE EMPLOYEE LAST ACTIVELY WORKED (Mo/Day/Yr) IF STILL ACTIVELY WORKING CHECK HERE ☐ AND SKIP TO #7

6. REASON FOR EMPLOYMENT TERMINATION ON ABOVE DATE

☐ Temporary Layoff ☐ Leave of Absence ☐ Disability ☐ Retirement ☐ Other Please Explain

7. DATE TO WHICH PREMIUMS PAID (Mo/Day/Yr)	8. EMPLOYEE'S AMOUNT OF INSURANCE (if based on SALARY, complete question 9 & 10)

9. SALARY ON DATE LAST WORKED	10. EFFECTIVE DATE OF THAT SALARY (Mo/Day/Yr)
$	

Please Complete #11,12, and 13 Only if claim is for a Dependent, otherwise skip to #14.	11. NAME OF INSURED DEPENDENT (LAST, FIRST, MIDDLE INITIAL)	RELATIONSHIP TO EMPLOYEE ☐ SPOUSE ☐ CHILD
	12. DEPENDENT'S AMOUNT OF INSURANCE $	13. EFFECTIVE DATE OF DEPENDENT'S COVERAGE (Mo/Day/Yr)

14. NAME OF EMPLOYER	15. TELEPHONE NUMBER OF EMPLOYER ( )

16. ADDRESS OF EMPLOYER (Street,City, State, Zip)

17. PRINT NAME OF AUTHORIZED REPRESENTATIVE	18. TITLE

SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE SIGNED
X	

PART 2-CLAIMANT'S STATEMENT - To be completed by the claimant, or authorized representative. All questions must be fully completed. Please be sure to sign and date the authorization.

1. LEGAL NAME OF CLAIMANT (Last, First, Middle Initial)	2. DATE OF BIRTH (Mo/Day/Yr)	3. POLICY NUMBER

4. ADDRESS (Street, City, State, Zip) ☐ NEW ADDRESS?

5. SOCIAL SECURITY NUMBER	6. HOME TELEPHONE NUMBER ( )	7. BUSINESS TELEPHONE NUMBER ( )

8. PLEASE DESCRIBE FULLY THE NATURE OF THE DISEASE OR INJURY FOR WHICH YOU ARE CLAIMING BENEFITS

9. DATE YOU WERE FIRST (Mo/Day/Yr) TREATED FOR YOUR PRESENT CONDITION	10. WERE YOU CONFINED TO A HOSPITAL ☐ Yes ☐ No	**IF YES, PLEASE PROVIDE INFORMATION BELOW.**

11.	NAME OF HOSPITAL	ADDRESS OF HOSPITAL	DATE ADMITTED (Mo/Day/Yr)	DATE DISCHARGED (Mo,Day,Yr)
a.				
b.				

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. The commission of insurance fraud may subject such person to criminal and/or civil penalties. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

CLAIMANT'S STATEMENT Continued on Reverse Side

PART 2 - CLAIMANT'S STATEMENT CONTINUED.

12. NAME AND ADDRESS OF PHYSICIAN(S) WHO TREATED YOU FOR YOUR CURRENT CONDITION.	DATE FROM	DATE TO
a.		
b.		
c.		

13. NAME AND ADDRESS OF PHYSICIAN(S) WHO TREATED YOU WITHIN THE LAST 5 YEARS FOR ANY CAUSE (IF NONE, PLEASE CHECK BOX ☐).	DATES	CAUSE
a.		
b.		
c.		

14. ARE YOU REQUIRED BY LAW TO USE THIS OPTION OF YOUR POLICY TO MEET CLAIMS OF CREDITORS ☐ Yes ☐ No	15. IF YES, PLEASE EXPLAIN	
16. HAVE YOU FILED OR DO YOU PLAN TO FILE FOR BANKRUPTCY ☐ Yes ☐ No	17. IF YES, PLEASE EXPLAIN	
18. ARE YOU REQUIRED BY A GOVERNMENT AGENCY TO USE THIS OPTION OF YOUR POLICY IN ORDER TO APPLY FOR, OBTAIN OR KEEP A GOVERNMENT BENEFIT OR ENTITLEMENT ☐ Yes ☐ No	19. IF YES, PLEASE EXPLAIN	

For the purpose of determining my eligibility for insurance coverage and benefits, I **authorize** any provider of health care, physician, medical practitioner, psychologist, chiropractor, hospital, including Veterans Administration Hospital, clinic or other health care facility, insurance company, consumer reporting agency, Social Security Administration, Internal Revenue Service, financial institutions, employer, workers' compensation, rehabilitation facility or other organization or person which has any medical or nonmedical records or knowledge including but not limited to my physical or mental health or financial information or employment, to give all such information it has to **Minnesota Life Insurance Company** (Company) or its authorized representative. This shall include but not be limited to information regarding any health history including all consultations, diagnoses, prescriptions, treatments, tests, as well as any information regarding alcohol or drug abuse, AIDS, or AIDS-related conditions.

I AUTHORIZE: Minnesota Life Insurance Company to request a report from the Medical Information Bureau (MIB), which is an association of life insurance companies that operates the Health Claim Index (HCI) for subscriber insurers. An HCI report contains the date(s) of past or present claims filed by me and the names of the companies but does not contain medical or other personal information. I understand **Minnesota Life Insurance Company** will report to MIB the date(s) of any past or present claims filed by me.

Upon receipt of a request from me, MIB will arrange a disclosure of any information it may have in my HCI file. If I question the accuracy of information in the file, I may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is PO Box 105, Essex Station, Boston MA 02112, telephone number (617) 426-3660.

I authorize the Company to release any information relevant to my insurance coverage and claim for benefits to persons or organizations performing services related to the claim, to other insurance carriers with whom I have coverage, or to any other public or private entity as may be required.

This authorization shall be valid for 30 months from the date it is signed. I have read and I understand this authorization. I know that I may request and receive a copy of it. A photocopy of this authorization is as valid as the original.

SIGNATURE OF INSURED	DATE SIGNED
X	

PART 3-ATTENDING PHYSICIAN'S STATEMENT-To be completed by the physician currently treating you. All questions must be fully completed. Please be sure to sign and date this form. Copies of medical records should also be attached.

NAME OF PATIENT	PHYSICIAN'S REFERENCE/PATIENT NUMBER

PATIENT HISTORY

1. HAVE YOU TREATED OR ADVISED THIS PATIENT FOR ANY CONDITION DURING THE PAST 5 YEARS OTHER THAN CURRENT CONDITION ☐ Yes ☐ No	2. IF YES, GIVE DIAGNOSIS AND DATES OF TREATMENT

3. HAS PATIENT RECEIVED TREATMENT FROM ANOTHER PHYSICIAN (This would be for time before current condition) ☐ Yes ☐ No	4. NAME AND ADDRESS OF PHYSICIAN

CURRENT CONDITION

1. PRESENT DIAGNOSIS INCLUDING ANY COMPLICATIONS (Describe fully) | WEIGHT | HEIGHT

2. SUBJECTIVE SYMPTOMS

3. OBJECTIVE FINDINGS (Including current x-rays, EKG's, laboratory data and any clinical findings)

4. DATE OF FIRST VISIT (Mo/Day/Yr) | 5. DATE OF LAST VISIT (Mo/Day/Yr) | 6. FREQUENCY ☐ Weekly ☐ Monthly ☐ Other (Specify)

NATURE OF SERVICE

1. LEVEL OF CARE PATIENT REQUIRES OR YOU HAVE AUTHORIZED
☐ SKILLED CONFINEMENT ☐ INTERMEDIATE CONFINEMENT ☐ CUSTODIAL CONFINEMENT ☐ HOSPICE CARE ☐ OTHER (Please Specify)

2. GIVE DATE PATIENT REQUIRED CONFINEMENT OR HOSPICE CARE
FROM TO

3. IS CONFINEMENT OR HOSPICE CARE STILL REQUIRED ☐ Yes ☐ No

4. IF NO, AS OF WHAT DATE

5. IS CONFINEMENT OR HOSPICE CARE EXPECTED TO CONTINUE UNTIL DEATH ☐ Yes ☐ No

6. IF NO, HOW LONG DO YOU ANTICIPATE THE CONFINEMENT OR HOSPICE CARE WILL BE NEEDED

7. IF SURGERY PERFORMED - WHAT TYPE - DATE OF SURGERY

8. LIST MEDICATIONS

PROGRESS

1. PATIENT HAS...(check one)
☐ RECOVERED ☐ IMPROVED ☐ UNCHANGED ☐ RETROGRESSED

2. IF RECOVERED, (Mo/Day/Yr) DATE OF RECOVERY

3. DO YOU EXPECT A FUNDAMENTAL OR MARKED CHANGE IN THE PATIENT'S CONDITION ☐ Yes-Improvement ☐ Yes-Deterioration ☐ No

4. IS THE PATIENT'S CONDITION TERMINAL ☐ Yes ☐ No

5. IF YES, WHAT IS THE PATIENT'S LIFE EXPECTANCY

6. PLEASE DESCRIBE THE BASIS FOR YOUR LIFE EXPECTANCY ESTIMATE

ATTENDING PHYSICIAN'S STATEMENT Continued on Reverse Side

PART 3 - ATTENDING PHYSICIAN'S STATEMENT - CONTINUED

7. DO YOU BELIEVE THE PATIENT IS COMPETENT TO ENDORSE CHECKS AND DIRECT THE USE OF THE PROCEEDS THEREOF	☐ Yes ☐ No	8. REMARKS

PRINT NAME OF ATTENDING PHYSICIAN	DEGREE	TELEPHONE NUMBER ( )
PHYSICIAN'S ADDRESS (Street,City,State, Zip)	PRINT NAME OF PERSON COMPLETING THIS FORM	
SIGNATURE OF ATTENDING PHYSICIAN **X**		DATE SIGNED

Please Attach Medical Records

Minnesota Life
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St. Paul, MN 55164-0114